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ABSTRACT

Prior to an advertising campaign directed toward the handicapped and their families, interviews with 995 adults, 481 handicapped persons, and 100 physicians were conducted. It was found that the lower economic group, which has the highest incidence of disability (17% as compared to 5% in upper economic households), has the least knowledge of how and where to seek help, and has more negative attitudes toward caring for the disabled. Among the general public, a much larger percentage of those in the lower economic group than in the upper and middle groups favors institutionalization of the handicapped rather than at-home care, and a much lower percentage favors having the handicapped work side by side with the non-handicapped. More of the handicapped have received medical services than have received vocational training. Results also showed the need for providing doctors with more information on how to steer patients toward rehabilitation. Discussed are suggestions indicated by the study for an advertising campaign designed to inform the handicapped and motivate them to seek rehabilitation services. (KW)

ED042295

Summary Report of a Study on the **Problems** of **Rehabilitation** for the **Disabled**

Conducted for WARWICK & LEGLER, INC. on behalf of THE ADVERTISING COUNCIL

By ROPER RESEARCH ASSOCIATES Incorporated

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FOREWORD

Purpose of The Study

This is the first phase of a two-part "before" and "after" study designed to evaluate an advertising campaign directed mainly towards the handicapped (or their families). The campaign will seek to inform the handicapped or disabled that rehabilitation help is available to them and to motivate them to seek this help. The campaign also will seek to increase awareness among the general public and among physicians that rehabilitation services for the disabled are available through public agencies.

There were several purposes of this study. One purpose is to provide a baseline against which later to evaluate the effectiveness of the advertising campaign among the disabled, physicians, and the general public in terms of awareness of the advertising itself, awareness that rehabilitation services are available, and in terms of action taken by the disabled in seeking these services. The first purpose of the study mentioned above will not be accomplished until the follow-up study is completed.

Other purposes of the study, however, will be served by the current study. Specifically, these are:

1) To get an indication of the extent to which the disabled who are likely candidates for rehabilitation services either know that such help is available or have sought such help.

2) To find out how easy or difficult it was for those seeking rehabilitation services to get information on where these were available.

3) To find out how satisfactory the results of rehabilitation services were among those who sought them.

4) To explore attitudes among the general public toward how the disabled should be cared for (in home versus institution) and in what ways and to what extend they should be helped to enter into the work force.

5) To determine from physicians their views as to major problems encountered in helping the disabled obtain rehabilitation services, and their awareness of the availability of such services in their areas.

How the Study was Conducted

The interviews in this study were obtained from a nationwide cross section of people 21 years of age and over. The original sampling plan called for interviewing a cross section of 1,000 adults, half men and half women. Based on figures supplied as to the incidence of handicapped people in the nation, it was estimated that we would find 200 such people, or family members of such people, in the cross section. In addition, all those interviewed in the cross section who did not have a handicapped member in the household were asked for the names and addresses of handicapped people they knew nearby. These names were used as a pool for getting an oversample of interviews in handicapped households. It was estimated that referrals would provide one and a half times as many interviews in handicapped homes as we found in the cross section, or 300 additional such interviews. Thus, the final sample was to consist of approximately 1,000 interviews among the general public, and 500 interviews in handicapped households with either the person most responsible for the handicapped person

or the handicapped person himself (200 interviews being common to both samples). In addition, 100 doctors were to be interviewed in the same interviewing points where the other interviews were conducted.

It subsequently was decided to eliminate as candidates for the interview those people over 65 years of age and those suffering from heart conditions, emphysema, TB, and cataracts. This resulted in eliminating from the pool of possible "handicapped" respondents two groups which account for a large percentage of the total handicapped people in the country--those over 65 and those with heart conditions. As a result, instead of the anticipated 20% yield of "handicapped" interviews in the cross section, the yield was 7%. Referral interviews gave a higher ratio than the estimated one and a half times incidence in the cross section, and ran at the 15% level. This meant, however, that the original cross section of 1,000 and referrals from it yielded only half of the 500 "handicapped" interviews anticipated.

In order to achieve the original quota of "handicapped" interviews desired, it was necessary, therefore, to screen an additional cross section of 1,000 adults. These additional interviews consisted only of a few short screening questions to locate additional handicapped people. These interviews were carried out in the same sampling points as the original sample, and yielded approximately the same number of "handicapped" interviews as the original sample, bringing the total number of "handicapped" interviews completed to 481.

There were 995 interviews completed among the general public, 69 of which were in households where there was a handicapped person. Screening interviews in the second round of interviews were not tabulated, since the sole purpose of doing them was to reach additional handicapped people, and they were not full questionnaires as were the original ones.

For both sections of the basic nationwide cross section, the sampling method used was modified probability sampling. Specific locations for interviewing were selected by probability methods down to the blocks in which interviews were made (or rural routes in the case of unincorporated rural open country and urban fringe areas). The selection of locations was divided into three stages. The first stage consisted of a selection of counties which were drawn at random proportionate to population from all counties in the United States. The second stage consisted of a selection of locations (city, town or open country) within each county, with the selections again made proportionate to populations living in different sizes of community within the counties. The third stage consisted of a selection of specific points within the cities, towns and unincorporated areas. In cities of 50,000 population and over, for which Census block statistics are available, blocks were selected at random proportionate to population. In smaller towns and cities, for which block statistics are not supplied by the Census, blocks were randomly selected from maps. In unincorporated open country and urban fringe areas, segments were selected at random from county maps. Interviewers were given a specific starting

household and a prescribed method of contacting households in each block and route. Controlled hours of interviewing as well as controls for sex, age and employed women, were used in order to insure proper representation of the various groups in the sample. The demographic assignments were made in accordance with Census statistics.

Interviews with the 100 doctors were carried out in the same sampling points as the cross section. A random selection of names of doctors was drawn from the Yellow Pages of the communities in which interviewing took place. Only general practitioners and internists whose practice is basically devoted to general diagnostic medicine were interviewed. Screening interviews were carried out on the telephone to determine doctors' eligibility for the interview, and appointments made for personal interviews with those who were eligible.

Interviewing was carried out for the original cross section of 1,000 people and resulting "handicapped" respondents during the period starting October 19 and ending November 9, 1968. Interviewing on the additional 1,000 screening and the balance of the "handicapped" interviews was carried out between November 14 and November 23, 1968. Doctors were interviewed between October 26 and November 23, 1968.

All interviews were carried out in the homes of respondents and, in the case of doctors, in their offices. There were three different questionnaires used in the study--one for the general public, one for the handicapped, and one for doctors.

Technical Note:

Throughout the tables for disabled respondents a number of percentages are based on less than 100 respondents. Percentages based on less than 100 are often unreliable and should be interpreted with caution. It should be noted, however, that results for disabled respondents by the various demographic breakdowns, although based on relatively small numbers of respondents, were quite consistent with results by those same breakdowns in the cross section. This consistency indicates the data on the disabled are more reliable than would normally be the case when bases are small.

Footnotes:

The footnotes added by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare are followed by the initials: SRS.

Questionnaires and Tables

In the interests of economy, this report is published without inclusion of the questionnaires and of the 73 tables produced by the study. Any reader desiring to consult these materials may arrange to do so through the Office of Public Affairs, Division of Special Projects in the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

HIGHLIGHTS

The major findings of the study are summarized in this section of the report, along with brief statements of the major results that support the findings. In a following section, results are discussed in detail and documented more fully.

1. One of the most important findings of this study is that the segment of the population which has the highest incidence of disability--the lower economic group--is the group which has least knowledge of how to deal with disability, is the most backward in attitudes towards caring for the disabled, and where the disabled are least likely to receive rehabilitation services.

   -- Incidence of disability appears* to be three times higher in lower economic households than in upper economic households--17% as opposed to 5%.

   -- Among the general public in households where there is no one disabled, a much larger percentage of those in the lower economic group than in the upper and middle groups favors institutionalizing of the disabled over having them live at home, and a much lower percentage favors having the handicapped working side by side with the non-handicapped.

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*Two things need to be said about the incidence of disability found in this study:

1. The three to one ratio of disability in the lower economic group could be affected by the fact that we were measuring only the incidence of disabled people living at home, and did not include those living in institutions.

2. Pre-survey estimates of the incidence of disabled people ranged from as low as one in ten to one in every two households. Because of this discrepancy, the incidence found in this study (7%) may have real significance. Not included in the 7% are disabled who are living in institutions, over 65 years of age, or those disabled by reason of heart conditions, emphysema, etc.

Note: Wherever the term "incidence" appears in this report, this is construed by HEW officials to mean "prevalence" as they use the latter term.

-- Over three times as many in lower economic non-disabled households as in upper economic households said they "didn't know" how they thought they might find out where rehabilitation services could be gotten if needed--38% as opposed to 11%.

-- A much lower percentage of lower economic disabled people (53%) have had any special therapy or training* than have the upper economic disabled (75%).

-- A much higher percentage (38%) of lower economic disabled people were reported to be non-functioning ("unable to work, attend school or keep house"), than were upper economic (21%), middle economic disabled people (25%).

2. Further education of the general public is needed to win wider acceptance for disabled people living at home rather than in institutions, and for having the disabled work side by side with the non-handicapped.

-- Surprisingly, large segments of the population support institutionalizing of the disabled. In reacting to three hypothetical case histories, almost half favored institutionalizing a mentally retarded young man, well over one-third favored institutionalizing a blinded young man, and a little over one-fifth favored institutionalizing a youth crippled by a birth defect.

*The term "special therapy and training" as used in this report means "vocational rehabilitation." -- SRS

-- Sizable groups felt all four case-history disabled (the three mentioned above and a middle aged stroke victim) should be employed in special workshops for the handicapped (ranging from 32% for the stroke victim up to 58% for the mentally retarded young man). Less than half supported work alongside the non-handicapped for any of the four types of disabled people.

3. Far more of the disabled have received medical services related to their disabilities than have received vocational training, but even the level of therapy may be a good deal lower than it should be.

-- More than half (56%) of the disabled were reported to have had some form of therapy. Only one-quarter had received any form of vocational training, and less than one-fifth (18%) had received both of these services.

4. The problem in providing rehabilitation services for the disabled seems to be a black and white, either/or proposition. The disabled are either steered toward rehabilitation (and early after the onset of the disability), in which case very few report any problems in getting information on where to get it, or they simply get no rehabilitation services at all. This suggests that those disabled who are fortunate enough to come in contact with people knowledgeable about rehabilitation have the path cleared easily for them, while those not fortunate enough to come in contact with people knowledgeable about rehabilitation simply do not get it at all.

-- The large majority of those who had received restorative medical services (81%) said it was "very easy" or "fairly easy" to get information on where it was available. 78% of those who had received vocational training reported similarly.

-- About two-thirds of those born with their disability who had had therapy had it started when they were under six years of age. Two-thirds whose disability occurred later in life and who had had therapy had it started within six months of when it occurred. Two-thirds who had had both medical services and vocational training said the vocational training either overlapped with therapy, or was started within a year after therapy ended.

5. Although not expressly stated by respondents, there is some evidence that the motivation to seek rehabilitation is not as strong as it might be.

-- The results of rehabilitation services were considered to be "satisfactory" for the majority of disabled people who had received these, yet large groups thought further training would be helpful, and most of them said they would know where to get it. However, they had not sought it.

-- A fair percentage of doctors (14%) volunteered as one of the major problems in providing rehabilitation services for the disabled "a lack of interest or desire to be helped on the part of the disabled."

6. Sources of information on where to get rehabilitation services appear to be a major problem---as was expected. Respondents in disabled households--particularly where no rehabilitation has occurred--do not have clear-cut ideas on where to go for information, if indeed they have any ideas at all. And, the sources from which disabled people who have had some form of rehabilitation got their information are indeed diverse.

-- The majority of respondents (69%) in homes where the disabled had had no therapy or training said they did not know where they might get such aid if it were desired.

-- Both the "non-disabled" public and the "disabled" group cite a wide variety of sources as to where they think they might find out where rehabilitation services are available. In fact, by far the major source of information on medical services for those who received these was the doctor or hospital. Actual sources of information on vocational aspects were much more scattered, with doctors and hospitals not playing nearly so important a role as in therapy. Schools, teachers, and boards of education appear to be among the major influences in the provision of vocational training for the disabled.

7. Doctors themselves need more information on how to steer patients towards rehabilitation--and perhaps more motivation to do so.

-- Although the vast majority of doctors say their role extends to seeing to it that patients get restorative therapy, and roughly half to two-thirds say their role extends to vocational training guidance, the actual percentage of patients who are steered to rehabilitation services seems to belie this. And, at least a third of the doctors stated they do not consider guidance involving vocational training as part of their role.

-- Doctors cite a wide variety of places where they would refer patients for restorative therapy--including hospitals and publicly supported rehabilitation services. For vocational training, they mainly think of state or local government facilities.

-- Quite a large percentage of doctors did not know of any publicly supported or low cost facilities in their areas for vocational rehabilitation services. Figures on this varied for the three case history patients--from half down to one-third. But at best, the fact that one-third didn't know of such facilities is not reassuring in terms of directions patients are given on getting rehabilitation services.

8. At the present time, the groups most important to reach with advertising on aid for the disabled are less aware of such advertising than is the general public.

-- Recall of advertising on information about aid for the disabled was highest among respondents in homes where there is no one disabled (30%). Next highest recall (24%) was by respondents in homes where there is someone disabled, and lowest recall was among doctors (15%).

-- Recall was highest among the upper economic levels who are most aware that rehabilitation services can help and who have been most inclined to obtain rehabilitation services. It was lowest among those most in need of help--the lower economic group, where need is highest, attitudes are least receptive, and having availed themselves of help is lowest.

Some Questions Raised By The Study

While the study produced meaningful results in a number of areas, it also raised--or left unanswered--certain other questions. Although some of the questions we see may not be new to experts in the field, we nevertheless feel a few of them are worthy of mention here--though not necessarily in order of importance:

What are the reasons for the higher incidence of disability in lower economic homes? Are a number of disabled people in the lower economic group <u>because</u> of their disability, or is this group simply more subject to disability?

The lower economic disabled have the highest percentage of "non-functioning" disabled, and also the lowest percentage who have received rehabilitation services. Is this a question of cause and effect? Are more of the other groups of disabled functioning better <u>because</u> more of them have had rehabilitation services, or is there a difference in the types of disabilities in this group that would account for it?

Since doctors appear to be the major influence in steering people towards restorative therapy, is the lower incidence of such therapy among the lower economic in part due to less personal attention by a physician?

Some Suggestions Indicated By The Study For Advertising

The scudy seems to us to have several clear-cut directions for any advertising campaign designed to inform the disabled about and motivate them to seek rehabilitation services.

1. First, as far as the disabled themselves are concerned, the most important group to reach is the lower economic, and less well educated segment of the population. This is true both because of the higher incidence of disability in that group, and because those better off are more likely to be under the care of doctors who will steer them towards rehabilitation services. In addition, attitudes toward disabled people are more advanced among the upper economic, better educated, and they are more likely to seek such services on their own.

Thus, it seems to us there are clear implications, both on the selection of media for advertising and on its content. Certainly the media called for seems to be the "mass media" rather than the "class," and the content should be geared to have an impact on the less sophisticated. (And one question that arises here is speculation over whether this is the group who is likely to "write to Washington for information.")

2. To encourage wider rehabilitation for the disabled, it appears highly important to reach doctors--and perhaps this means a special campaign, both in terms of media and content. Doctors play a very important role in guiding patients to restorative therapy, yet need more information on it themselves, and appear to be least aware of general advertising. They appear to be playing a relatively minor role in guiding patients toward vocational training.

3. Special campaigns directed toward schools and teachers could be fruitful in encouraging wider vocational rehabilitation services for the disabled.

4. Finally, the one thing that seems to need stressing is that there <u>is</u> help available, but equally important along with that theme, that there is a central, easily accessible source of information on how and where to get that help. We realize that this is the aim of the current campaign, and we point out the need only to stress the importance of the aim.

DETAILED FINDINGS

THE GENERAL PUBLIC

Incidence of Handicapped in the General Population

In this study we were seeking those handicapped people who were likely prospects for rehabilitation. Based on our limited definition of "handicapped", the incidence of disabled people was somewhat lower than expected. Seven per cent of all households reported someone in the home under 65 disabled either by a physical or mental condition. Another 4% (who did not have anyone under 65 disabled in the home) reported someone over 65 in the home who was disabled.

There is much higher incidence of disabled people in the lower economic group than in the upper and middle groups. In fact, there is almost direct correlation of the incidence of disability with economic groups.

	Total	Upper group	Middle group	Lower group
Number of households	995	318	533	126
	%	%	%	%
TOTAL WITH DISABLED PEOPLE	11	5	12	17
Disabled person under 65	7	3	8	11
Disabled person over 65	4	2	4	6

The reasons for the higher incidence of disabled people in the lower economic group could be many, and we can only speculate as to what they are. The disability could be the cause of people being in the lower rather than the middle or upper groups because of decreased earning power. On the other hand, the lower group may be more subject to accidents and illnesses that cause

disability because they live in a less protected and therefore more hazardous atmosphere--more hazardous manual occupations, housing and equipment that is not as well kept up, neighborhoods that are not as clean and well kept up, etc. Undoubtedly, many things could account for it, but whatever the reasons, the difference is marked.

It should be noted that when we speak of "incidence of disability" we mean the percentage of <u>households</u> in which there is one or more disabled people, not the incidence of disabled people in the population. Also, the figures do <u>not</u> include the disabled who are living in institutions, and this could explain the economic level difference in apparent incidence--the upper economic levels being better able to afford sending their disabled to institutions, and thus, not reporting as many disabled "in the home." But we doubt this because the upper economic group is also better able to afford to care for their disabled at home, and also show more inclination to favor having disabled people live at home rather than in an institution.

The survey shows that a majority of the public has some contact with disabled people. 47% of all respondents reported they know someone under 65 who is disabled, and another 4% (who did not know someone disabled under 65) reported they know someone over 65 who is disabled. This is in addition to those who have someone disabled in their homes. Thus, only 38% of those interviewed did not know anyone who is disabled.

We feel these figures present a fairly solid measure of the incidence and acquaintance with disabled people who are not institutionalized--despite the fact that "disabled" or "handicapped" can mean different things to different people and covers a wide range of physical and mental conditions.

In lead-in questions prior to asking people about the presence of disabled people in their homes or their acquaintance with such people, we used a list of illustrative conditions that can cause disability. Thus, respondents had had time to consider what types of conditions we meant when "disabled" or "handicapped" was mentioned. In addition, a disabled person was defined as someone "who has a permanent or continuing physical or mental condition--either one he was born with or one that developed later--that keeps him or her from doing the things that the average person can do."

The Public's Perception of Which Disabilities Can Be Helped by Therapy And Training

As noted earlier, respondents were shown a list of conditions to illustrate what we meant by "disabled" or "handicapped" people. Basically to give them time to consider these conditions before we asked about incidence in their homes and acquaintance with disabled people, but also to explore opinions as to the helpfulness of restorative therapy and training, respondents were asked which of the conditions they thought therapy and training would help, and then which they thought therapy and training could do little to help. Restorative therapy and training were thought to be helpful in each case by a majority of respondents--though to varying degrees. 42% said <u>all</u> could be helped, and others singled out specific <u>ones</u> and omitted others. Correspondingly, relatively small percentages named conditions they thought therapy or training could do little to help, and virtually no one said "all" <u>couldn't</u> be helped. Including the 42% who said "all" could be helped, answers to the two questions were as follows:

	Special therapy or training	
	Would help	Would do little or nothing to help
Number of respondents	995	995
	%	%
Blindness	80	9
Deafness	76	10
Cerebral Palsy	65	15
Loss of hand or arm	79	7
Loss of foot or leg	77	8
Partial paralysis due to stroke	76	9
Partial paralysis due to spinal injury	66	14
Mental retardation	74	11
Arthritis (severe)	65	18
Birth defect of arms or legs	73	9
Crippling due to polio	84	4
Crippling due to muscular dystrophy	65	16

Despite the generally high level of conditions thought to be benefited by therapy and training there was enough variation to highlight one point. The condition most named as one that could be helped by therapy and training was "crippling due to polio." Over the years, the benefits of therapy and training for polio victims has probably had more publicity than any other particular form of rehabilitation. This suggests that a concerted campaign can be effective in educating the public about aid for the disabled. It was noteworthy that there was less variation by level of education in the percentages thinking polio could be helped by rehabilitation than for any other conditions on the list.

Attitudes Toward Rehabilitation For The Disabled Among Those With No Disabled Person in The House

Those respondents who did not have a disabled person in the house under age 65 were asked a series of questions designed to explore their attitudes toward home versus institutional care for the disabled and towards employment for the disabled. They were also asked two brief questions on their knowledge of the availability of rehabilitation services for the disabled, and finally, about their awareness and recall of advertising on where to get information on help for the disabled.

In order to explore attitudes toward home versus institutional care for the disabled, and towards their employment, respondents were given four brief case histories of men with different and fairly representative types of disabilities, and were asked questions specifically about them. The next few sections of the report deal with results of these questions asked in "non-disabled" households. To make results clearer, the four case histories presented to respondents are given below.

(8) Blinded Man

John A., aged 23 and unmarried, has just lost his sight in an accident and quite naturally is very bitter and depressed. While he will receive enough money from an insurance policy to pay for his keep in his parents' home, there won't be much left over.

(9) Mentally Retarded Young Man

Now, take the case of Thomas B. He is aged 20 and mentally retarded. Outwardly normal, he has the intelligence of an average 8 year old child. He can care for himself, do simple chores, and read and write at the third grade level.

(10) Stroke Victim

Now take the case of Peter C. He was 55 when he had a stroke that left him partially paralyzed. Now, three months later, he still cannot walk without great difficulty and while his mind is as clear as ever, his speech is somewhat fuzzy. While it is not essential for his family to get any money that he could make, and he can live at home, he is somewhat restless because of having nothing useful to do.

(11) Crippled Youth

Finally, take the case of Charles D. He is 17 and has been suffering from a birth defect which prevents him from walking and gives him very limited use of his arms and hands. He can get around the house in a battery-powered wheelchair but cannot get out of the house unless he is carried. However, he has just about finished the equivalent of high school work at home and is considered to be college material.

Attitudes Towards Home Versus Institutional Care for The Disabled

Three of the case histories--all except the stroke victim--were concerned in this question.

A surprisingly large segment of the public favors institutional care for the three types of disabled people discussed--though there was considerable variation in the size of the groups supporting this for the three types. Almost half (46%) said the mentally retarded young man should live in an institution rather than at home. This is perhaps less surprising than the number of those supporting institutional care for the other two types, since there may be some fear on the part of people that a mentally retarded young man may be a potential danger to society. But well over one-third (37%) said the blinded man should live in an institution. There was more support for the crippled youth living at home than for the other two types.

In all three cases, a fairly large percentage answered "it depends" when asked about home versus institutional care. Most of the qualifications centered around the family's ability to care for the disabled person.

	Blinded man	Mentally retarded young man	Crippled
Number of respondents	926	926	926
	%	%	%
LIVE AT HOME	40	38	62
LIVE IN INSTITUTION	37	46	22
IT DEPENDS (Volunteered)	20	12	13
Major comments:			
Up to the individual, what he wants	5	1	2
Up to the parents, family, if family wants him at home	5	4	2
If the family is capable of caring, and in handling him	4	4	3

In all three cases the better educated respondents were less inclined to support institutionalizing of the handicapped men than were the less well educated. Even so, there were sizable groups among the better educated who said the men should live in an institution--over one-third for the blinded man, and over two-fifths for the mentally retarded young man.

	College	High school	Grade school or less
Number of respondents	259	463	200
	%	%	%
Blinded man			
Live at home	36	43	38
Live in institution	35	37	43
It depends	26	18	15
Mentally retarded young man			
Live at home	39	38	37
Live in institution	42	48	50
It depends	17	12	8
Crippled youth			
Live at home	64	64	54
Live in institution	16	22	29
It depends	16	11	14

And, the group in which the incidence of disability is greatest--the lower economic group--is the group that most favors institutionalizing of the disabled.

	Upper group	Middle group	Lower group
Number of respondents	307	490	112
	%	%	%
Should live in institution:			
Blinded man	35	37	47
Mentally retarded young man	45	46	54
Crippled youth	17	22	31

Attitudes Toward Employment for The Disabled

Respondents were asked the same four-part scaled question on attitudes toward employment for the four case history examples. The choices were that they not work at all, get training for work only if they especially want to, get training to work in a special workshop for the handicapped and get training to work side by side with non-handicapped people.

The results of these questions show that there is still a great deal of work to be done in winning public support for the handicapped working side by side with the non-handicapped. Sizable groups felt all four types should work in special workshops for the handicapped. And while there was considerable variation in the size of the groups backing employment along with the non-handicapped for the four types, less than half supported this kind of employment for any of the four types. There was less support for the mentally retarded young man working with the non-handicapped than for any of the other three types.

	Blinded man	Mentally retarded young man	Stroke victim	Crippled youth
Number of respondents	926	926	926	926
	%	%	%	%
Should be:				
Cared for by others and not work at all	2	10	4	3
Trained to work only if he especially wants to	7	13	23	9
Encouraged to get special training to work in special workshop for handicapped	45	58	32	39
Encouraged to get some special training and to work side by side with non-handicapped	44	16	37	46
Don't know, no answer	2	3	4	2

Once again it is the group most subject to disabilities that is least favorable to the disabled working side by side with non-handicapped people--the lower economic group. They are much more inclined than the middle and upper groups to favor the disabled not working at all or working in a special workshop. Also, the less well educated follow that same pattern.

	Economic groups			Educational level		
	Upper	Middle	Lower	College	High school	Grade school or less
Number of respondents	307	490	112	259	463	200
	%	%	%	%	%	%
Blinded man						
Not work at all, or only if he wants to	4	10	20	4	7	21
Work in special workshop	39	46	49	31	46	61
Work with non-handicapped	55	42	27	62	46	17
Mentally retarded young man						
Not work at all, or only if he wants to	15	25	34	16	25	27
Work in special workshop	64	58	46	62	57	55
Work with non-handicapped	19	15	11	19	16	12
Stroke victim						
Not work at all, or only if he wants to	26	29	27	25	25	36
Work in special workshop	30	32	39	26	35	36
Work with non-handicapped	42	36	29	46	37	25
Crippled youth						
Not work at all, or only if he wants to	10	13	19	7	12	21
Work in special workshop	31	42	48	31	40	47
Work with non-handicapped	56	44	30	59	46	30

In this study we did not explore the reasons behind the generally high support of special workshop employment for the handicapped as opposed to employment with the non-handicapped. Therefore, we can only speculate on this. We suspect that in some cases people thought a special workshop better for the disabled people in question because they felt it would be easier for the disabled person to work under those conditions. We also suspect that in a number of cases people supported special workshop employment because of some aversion to the idea of working with handicapped people.

In any event, it appears that further education of the public is necessary to win support for the handicapped working with the non-handicapped.

Knowledge of Rehabilitation Facilities And Services

Respondents with no disabled people in their household were asked two brief questions dealing with their knowledge of rehabilitation facilities and services. One question asked if they wanted to see that someone with a disability got restorative therapy and training, how they thought they might find out where these services were available. The other asked, as far as they know, whether there are state or federal agencies set up to help people with disabilities get the restorative therapy and training they need.

Answers to where they might find out where therapy and training were available were scattered. The leading answer was "from a physician or doctor" but, in addition, there was relatively high mention of volunteer groups and government agencies or departments. Differences in answers by the lower economic group as opposed to the others were most interesting. The upper group was much more inclined to think of the private medical

sources (doctor or hospital) than was the lower group. The lower group tended much more to think of the Welfare Department. And, the lower group was lower on mention of other government agencies than was the upper group. Most important of all, perhaps, was the high percentage of the lower group who "don't know" where to find out where aid is available--38%, as opposed to 11% in the upper group. The lack of knowledge by the lower economic group about where to find out about therapy and training is particularly significant in view of the fact that this is the group with the highest incidence of disability.

	Total	Upper group	Middle group	Lower group
Number of respondents	926	307	490	112
	%	%	%	%
Major sources:				
From physician, doctor	22	26	22	15
From a hospital	12	12	13	7
Through medical, rehabilitation social centers or societies, volunteer groups	18	20	18	12
Through the health department	13	15	13	7
Through some state, county, city agency, office	13	17	13	3
Through the Department of Welfare	10	7	9	19
Don't know	19	11	20	38

A fairly large percentage of the public (71%) thinks there <u>are</u> state or federal government agencies set up to help people with disabilities get the restorative therapy and training they need. Very few (6%) think there are <u>no</u> such agencies, and about one-quarter (23%) said they didn't know. Again, a much larger percentage of the lower economic group said they didn't know about this than did the upper and middle groups.

	Total	Upper group	Middle group	Lower group
Number of respondents	926	307	490	112
	%	%	%	%
Yes	71	81	70	46
No	6	3	6	13
Don't know	23	16	23	42
No answer	*	-	1	-

*Less than .5 per cent

THE DISABLED OR HANDICAPPED

In reading the results of data on the "handicapped" sample, it should be kept in mind that results are not truly projectable because of the way respondents were reached. The majority of respondents in handicapped homes were reached thr. gh referrals from the cross section. Answers, therefore, should be representative of what happens in the way of rehabilitation when people are disabled or handicapped, but such things as the incidence of handicapped in this group as to sex, age, nature of the disabilities, etc., cannot be projected to the total population.

Incidence And Nature of Disabilities

In this study, 63% of the disabled people discussed were male, and 37% were female. A large percentage (37%) were sons of the respondents. It is likely that the higher percentage of males in the group interviewed is due to disabled males simply being more "visible" in society than disabled females, and therefore, there were more referrals to households where there is a disabled male. In the cross section, there were more disabled females (4%) than disabled males (3%).

A large proportion of the disabled people in this study (68%) suffered from physical disabilities, with the other 32% afflicted by mental disabilities. The types of physical disabilities covered a wide range. A large proportion of the mental disabilities were accounted for by mental retardation. And, it is noteworthy that the mentally retarded, who accounted for the largest single group of disabled in this study, are the ones the general public is most inclined to institutionalize, and is least inclined to see work along with non-handicapped people. Major disabilities reported were as follows:

Number of respondents	481
	%
PHYSICAL DISABILITIES	68
Cerebral palsy	7
Polio, crippled due to polio	7
Paralyzed, partial paralysis (not due to polio)	6
Rheumatoid arthritis, arthritis, severe arthritis	6
Stroke, disability due to stroke	5
Loss of limbs	4
Blindness	4
Multiple sclerosis	3
Spinal defects	3
Deaf, partially deaf	3
Other	19
MENTAL DISABILITIES	32
Mental retardation	26
Brain injury	4
Other	2

45% of the disabled people in the study had been born with their disability, 55% had it occur later in life. This was true of both men and women. 36% are now under 18 years of age, 64% are now 18 years of age or older.

Current Status of Disabled Respondents

About one-quarter of the disabled people in this study appear to be completely dependent and non-functioning because of their disability. Respondents were given a list of statements that included types of school attended, types of employment, and one concerning inability to work or attend school or keep house, and asked which statement applied to the disabled person in question. There was some duplication of answers, but 28% picked the statement "Because of disability is unable to attend school or to be employed or to keep house." (An unduplicated count reduces this figure to 26%.) This was more true for men than women. Respondents said the statement applied to 31% of the men, as opposed to 21% of the women. And, the group with the largest incidence of disabled people--the lower economic group--also has the highest percentage of "non-functioning" disabled. 38% of the lower economic disabled were reported to be unable to do anything, as opposed to 21% in the upper group, and 25% in the middle group.

An unduplicated count shows that 36% of the disabled people in the study do <u>not</u> seem to be hindered from functioning in society. They either attend regular school, are employed at a job with non-disabled people, are self-employed, or keep house full time. This is not to say that they function as effectively as they might were they not disabled, but they are at least moving in the mainstream of society. Again, this is more true of the upper and middle income groups than the lower groups--40% in the upper group, 42% in the middle group, and 28% in the lower group. (These latter figures may be inflated by two or three points because of duplication.)

Another sizable group (31%) are hindered by this disability to the extent that they attend special schools rather than regular schools, work in special workshops for the disabled, or are only able to do some (but not all) of their housework.

The complete picture on the current status of the disabled people in this study is shown in the following table:

	Total
Number of respondents	481
	%
FULLY FUNCTIONING	36
Attends regular school with non-disabled people	18
Employed at a job working with non-disabled people	11
Self-employed	4
Keeps house full time	5
HINDERED, BUT FUNCTIONING	31
Attends special school for disabled people	22
Employed at a job in a special shop or office for the disabled	3
Does some housework, but is not able to do everything	15
NON-FUNCTIONING	26
Because of disability is unable to attend school or to be employed or to keep house	28
DON'T KNOW, NO ANSWER	7

Therapy And Training

It was reported that about two-thirds (64%) of the disabled respondents in this study had received, at some time, some restorative therapy or vocational training aimed at helping them function better with their disabilities. Once again, it is the group most affected that has had the least of these services--the lower economic group. Only a little over half of them had had therapy or training as opposed to 75% of those in the upper economic groups.

The reasons given as to why therapy or training had not been received by the disabled were scattered, with the two leading ones that these services were not needed or wouldn't help. Only 4% of all respondents said they "didn't know where to get it," but again, this answer was a good deal higher in the lower economic group than in the upper and middle groups.

	Total	Economic groups		
		Upper	Middle	Lower
Number of respondents	481	77	272	117
	%	%	%	%
Received therapy or training				
YES	64	75	65	53
NO	35	25	33	47
Major reasons:				
Therapy or training not available, does not respond to therapy	8	6	6	15
Doesn't need therapy or training	7	9	8	4
Don't know where to go, where to get it	4	3	4	7
Too expensive	2	1	1	3
Have to wait, too young	2	3	2	3
Just haven't looked into it	2	-	1	3
DON'T KNOW	1	-	1	-

Respondents who said the disabled person in their household had not received therapy or training were further asked, if such services were desired, whether they knew where they might get them. The majority (69%) said they did not know. When asked how they thought they might find out, the major reply was from a physician or doctor. Those who said they did know where to go for therapy or training tended more to think of a medical center or vocational rehabilitation center. Major answers were as follows:

Number of respondents	169
	%
YES--WOULD KNOW WHERE TO GO, WOULD GO TO:	31
Medical center, creative workshop, therapy school	9
Vocational rehabilitation center	7
Physician	4
NO--WOULD NOT KNOW WHERE TO GO, WOULD FIND OUT FROM:	69
A physician, doctor	22
A hospital	4
The welfare department	4
Some state, county, city agency, office	4

Types Of Therapy And Training Received

Far more of the disabled people in this study had received restorative therapy (over half) than had received vocational training (one-quarter). Less than one-fifth had received both therapy and vocational training. And, substantially fewer in the lower economic group had received either service than had those in the upper group.

	Total	Economic groups Upper	Middle	Lower
Number of respondents	481	77	272	117
	%	%	%	%
HAVE HAD THERAPY	64	75	65	53
Total therapy	56	69	56	49
Total vocational training	25	27	26	17
Therapy only	38	48	38	35
Therapy and training	18	21	18	14
Training only	7	6	8	3
Don't know type	1	-	1	1
HAVE NOT HAD THERAPY OR DON'T KNOW	36	25	35	47

As might be expected, more men (28%) than women (19%) had received vocational training. Slightly more women (60%) than men (54%) had received restorative therapy.

History of Restorative Therapy

There was little evidence in this study that those who had had restorative therapy or vocational training had experienced much delay in having the therapy started.

The large majority of those who were born with their disabilities and who had received restorative therapy or vocational training had first had such service started early in life. 64% had it started when they were under six years of age, another 17% had had it started when they were between six and nine years of age, and another 7% between the ages of ten and fourteen. Thus, 88% of those born with their disabilities who had received restorative therapy had first had it started by the time they were fourteen years old.

Similarly, there was little evidence of any delay in the start of restorative therapy or vocational training among those whose disabilities occurred late in life and had received restorative therapy. About one-third had had restorative therapy started almost immediately--right in the hospital (19%), or immediately following the end of definitive medical treatment (13%). And, in total, two-thirds had had restorative therapy started within six months after the disability occurred, half within two months.

The doctor or the hospital is the major source of finding out that restorative therapy is available. 44% of those who had received such therapy had found out about it through their doctors, and 20% through the hospital. Few mentioned hearing about it through government agencies, although the welfare department was mentioned by 4%. This suggests two things: 1) that efforts to inform doctors and hospitals of rehabilitation services could be effective, and that they are important to reach in any campaign to encourage wider rehabilitation for the disabled; and 2) that the lower incidence of rehabilitation among the lower income group may, in part, be due to the lack of personal attention by a physician.

The large majority of those who had received restorative therapy had had little trouble in getting information on where it was available. Almost three-quarters (73%) said it was "very easy," and 8% said it was "fairly easy." Seven per cent said it was "fairly difficult," and 9% "very difficult." Interestingly, here for the first time, we see little difference between the answers of the lower and higher economic groups. Although the bases are small, a large majority in both groups (74% in the

upper group, 81% in the lower group) said it had been "very easy" to get information on where restorative therapy was available.

Among the few who reported difficulty in getting information on where restorative therapy was available, the major problems cited were that it was "hard to find help getting information" (24%), that "nobody knows what they are doing, doctors don't realize what is available" (19%), and "had to wait, took a long time to find school, get funds" (16%).

In the majority of cases, results of the restorative therapy were considered to be satisfactory. Over half (58%) said it had been "very satisfactory," and 21% said it was "fairly satisfactory." 13% said it was "not very satisfactory," and 6% said it was "not at all satisfactory."

The group who said it was not satisfactory was too small to make answers meaningful as to what wasn't satisfactory about the therapy, but indicate mainly that the therapy didn't have the results expected, or provided only temporary relief, or that therapy couldn't help because of the nature of the disability.

Despite the high level of satisfaction with the results of restorative therapy, a large group (58%) said that further therapy would be helpful (or any therapy, since the small group who had received only vocational training were also asked this question). It was thought that 32% could not be further helped. The latter group was mainly divided among those for whom nothing further could be done (12%), and those who are getting along well and don't need more attention.

While a large percentage (63%) of those who said further restorative therapy would be helpful said they would know how to find out where to get it, it is significant that one-third said they did not know how to find out about it.

The physician or doctor still leads as the source of finding out where restorative therapy was available, with other major sources the hospital, rehabilitation or vocational centers, and schools. Major answers were as follows:

Number who think further therapy would be helpful	205
	%
YES--WOULD KNOW WHERE TO GET THERAPY	63
Physician, doctor	13
From the hospital	9
Contact rehabilitation, vocational center	9
Through the school, parent-teachers council	9
Contact state, county agency	5
Through welfare, social worker	3
Easter seal place	3
NO--WOULD NOT KNOW WHERE TO GET THERAPY	33
NO ANSWER	4

The answers on the helpfulness of further restorative therapy raise questions in themselves. A large group feels that further therapy would be helpful, and almost two-thirds of them say they know where to get it. Yet--the fact remains that they have not done so. Why this is true is an unanswered question. Another question is why such a high percentage--33%--do not know how to find out where therapy is available. All of these people have had some form of rehabilitation service, and should have some idea about sources of information. But they do not seem to. This seems to us to highlight what has shown up throughout the study--the fragmented sources from which people do get this information on rehabilitation services, and the lack of any well-known, central source of information about them.

History Of Vocational Training

As with restorative therapy, we saw little evidence of delay in the start of vocational training among the group that had received it. Over half (55%) of those who had had both restorative medical services and vocational training said the vocational training had overlapped with the medical service. Another 11% said it had been started within a year after restorative therapy was ended. There were only 32 disabled people (out of 481) in this study who had received only vocational training, and these were divided between 18 who had been born with their disabilities, and 14 whose disabilities had occurred later. These groups are too small to provide any real indication of how soon vocational training was started, but most had had it started early in life, or soon after the disability occurred.

Schools and teachers appear to play an important role in steering people to vocational training. They were the major source cited as to how those who had had vocational training had found out it was available. Doctors and hospitals were also major sources, but they do not play anywhere near as important a role in steering patients to vocational training as they do in steering them to restorative therapy. Major sources named were as follows:

Number of respondents	118
	%
School, teachers at school	19
Board of education, state education department	9
Through physician, doctor	16
Through the hospital	14
Through welfare, social worker	6
Through friend, neighbor	5

Thus, it appears that finding out where vocational training is available is a rather chancy experience, with no one really outstanding source used.

Despite this, the majority of those who had had vocational training had not experienced difficulty in finding where it is available. 70% said it was "very easy," and 8% said it was "fairly easy." It is noteworthy, however, that 20% had experienced problems. 6% said it was "fairly difficult," and 14% said it was "very difficult."

The number who had had problems is too small to pinpoint with any accuracy what the problems are. In this small group, they centered on the difficulty in finding information, and the long time it took to find the school or funds.

The major type of vocational training received by this group was training in how to do a specific job (42%). 27% said they had received guidance as to the kind of job training to get, only 9% said they had actually been placed in a job. In addition to these major types of training, there was a wide scattering of other types mentioned--none of enough importance to mention.

A majority (75%) who had received vocational training felt the results were satisfactory. 56% said it was "very satisfactory," and 19% said it was "fairly satisfactory." 8% said it was "not very satisfactory," and 12% said it was "not at all satisfactory."

The group who had problems was small, but in the main, the problems cited were that the disabled person was "not capable of doing the job" (20%), the "teacher was not satisfactory" (15%), and "had to wait to be placed" (13%).

Despite the high level of satisfaction with the results of vocational training, a large group (66%) said that further training would be helpful for those who had already had it. And, about half (47%) who reported their disabled family member had only had restorative therapy, thought vocational training would be helpful. The main reasons why respondents thought vocational training or further training would not be helpful was that it is "not needed, disabled is employed, goes to school, has sufficient training" (13%), or that "nothing else could be done, the condition is too severe" (11%).

A little over half (57%), who thought vocational training or further training would be helpful, said they would know how to find out where it is available. Again, the school was one of the major sources cited, as was the rehabilitation or vocational center. Perhaps the most significant thing on this question, however, is the 40% who said they didn't know how to find out where to get vocational training.

Number who think training, or further training, would be helpful	194
	%
YES--WOULD KNOW HOW TO FIND OUT WHERE TO GET IT	57
Major sources:	
Through the school, parent teachers council	16
Contact rehabilitation, vocational center	15
Physician, doctor	8
From the hospital	4
Contact state, county agency	6
Through welfare, social worker	5
NO--WOULD NOT KNOW HOW TO FIND OUT WHERE TO GET TRAINING	40

The same pattern seen in a similar question on further restorative therapy was observed here. A large group feel that vocational training, or further training would be helpful, and over half of them say they know where to get it. Yet they have not done so. And, despite experience with some form of rehabilitation, a high percentage (40%) do not know how to find out where training is available.

Respondents in "disabled" households were asked the same question as the general public as to whether there are state or federal government agencies set up to help people with disabilities get the restorative therapy or vocational services they need. Rather significantly, substantially fewer people in homes where there is someone disabled think there are such government agencies, than in homes where there is no one disabled. Three times as many think there are no such agencies, and a large proportion don't know. And, once again, the group most in need of such information--the lower economic group--has the lowest percentage thinking there are such agencies.

	Respondents in		Disabled homes whose economic group is		
	Non-disabled homes	Disabled homes	Upper	Middle	Lower
Number of respondents	926	481	77	272	117
	%	%	%	%	%
YES	71	53	65	55	38
NO	6	19	14	19	24
DON'T KNOW	23	28	19	25	38
NO ANSWER	*	*	1	-	1

*Less than .5 per cent

DOCTORS

Experience With Handicapped Patients

The large majority of doctors in this study (general practitioners and internists who concentrate on general diagnostic medicine) come into professional contact with the handicapped. 99% reported having seen professionally during the past two years some patients who were disabled in some way. 89% reported having seen professionally during the past two years some patients who have become disabled during that time because of an accident or illness. As to the number seen, 43% reported having seen in the past two years 25 or more who had a disability, and 29% reported having seen 25 or more who had become newly disabled in the past two years.

How Doctors See Their Role in Getting Rehabilitation Services For Patients

At different places in the questionnaire, doctors were given three brief hypothetical case histories of patients with different type of disabilities and asked which of three statements best expressed how far they saw their role extending beyond medical treatment. The three case histories concerned a recently blinded man, a stroke victim and a recent leg amputee. In all three cases, the majority of doctors said they felt their role included seeing to it that the patient gets restorative therapy, and is then guided into vocational aspects of vocational rehabilitation. This was more true for the blinded man and the amputee than for the stroke victim, however. And, while the largest group felt their role extended all the way to vocational rehabilitation, there were sizable groups who felt their role stopped at helping these patients get restorative therapy and did not extend to helping them meet vocational needs. Only a few said their role ended with definitive medical treatment, and a few said it "depended." Most of

the doctors who gave one of those answers when pressed as to whether they would assist patients in getting vocational rehabilitation, if asked about it, said they would do so.

	Blinded man	Stroke victim	Leg amputee
Number of doctors	100	100	100
	%	%	%
Professional responsibility and competence ends with medical treatment*	2	2	3
Professional responsibility and competence includes seeing to it that the patient gets some form of physical therapy or rehabilitation**	28	42	30
Professional responsibility and competence includes seeing to it that the patient gets physical therapy or rehabilitation** and is then guided into vocational guidance and training	65	50	61
It depends (volunteered)	5	4	4
Don't know	-	2	2

Thus we see that at least one-third of the doctors do not see their role involving assistance in getting vocational rehabilitation services for their disabled patients. Further, there is a wide discrepancy between the percentage of doctors who said their role extends to vocational training and the percentage of disabled people who have had vocational training (25%). This leads us to believe that there is some inflation in doctors' answers on this role in relation to vocational training.

Where Doctors Would Refer Patients For Physical Rehabilitation

Doctors gave a wide variety of answers as to where they would refer the three "case history" patients for physical rehabilitation. For all three, the

* "Medical treatment" as used here is construed to mean "definitive medical treatment." -- SRS

** "Physical therapy or rehabilitation" is construed to mean any restorative medical services. -- SRS.

leading answer was a "hospital." The next most mentioned place was a "state rehabilitation center." A "city or county rehabilitation center" was also mentioned by a fair sized group. For the stroke victim, doctors were more inclined to think of a hospital or a private therapist than they were of state or local centers. Major answers on where they would refer the three "case history" patients were as follows:

	Where doctors would refer		
	Blinded man	Stroke victim	Leg amputee
Number of respondents	98	97	97
	%	%	%
Hospital	25	40	30
State rehabilitation center	19	12	14
City, county rehabilitation center	12	10	8
Vocational rehabilitation center, vocational school	10	4	6
To a society, a center	10	4	3
Private therapist	9	11	14
Department of rehabilitation	9	4	5
Doctor, specialist, therapist	8	4	7
To an institute for the disabled (Perkins, Goodwill, Braille)	6	8	5
University, college facility	5	6	10

Where Doctors Would Refer Patients For Vocational Training

State or local government centers were the two leading places doctors said they would refer the three "case history" patients for vocational training. There was a wide scattering of other answers, and 11% said they didn't know where they would refer the blinded man and leg amputee, and 13% didn't know where they would refer the stroke victim. Doctors tend to be somewhat less knowledgeable about where to refer patients for vocational training than about where to refer them for further medical services related to rehabilitation. Major answers on references for vocational training were:

	Where doctors would refer		
	Blinded man	Stroke victim	Leg amputee
Number of respondents	98	97	97
	%	%	%
State rehabilitation center, vocational center	32	25	27
City, county rehabilitation center, vocational center	12	18	14
Vocational rehabilitation center, vocational school	9	9	6
Hospital	5	11	14
Don't know	11	13	11

Knowledge of Publicly Supported Or Low Cost Facilities For Vocational Rehabilitation

Quite a large percentage of the doctors in this study said they did not know of any facilities in their area that are publicly supported or available to the public at low cost for vocational rehabilitation of the three "case history" patients. Half (49%) said they did not know of such facilities for the blinded man, 44% for the stroke victim, and 34% for the leg amputee. The higher figure for the blinded man, as opposed to the leg amputee, may well not mean that doctors are less aware of publicly supported or low cost facilities for the blind than for amputees, but may be due to additional thought by doctors about the whole question in general. The blinded man was the first one asked about, the stroke victim next, and the leg amputee last. Thus, the apparent rise in knowledge of public facilities for the leg amputee may in fact be due to probed questioning. This aside, however, taken at its best, the fact that one-third of the doctors did not know about such facilities is not reassuring in terms of the aid and direction patients are given by doctors in getting information about rehabilitation.

The places cited by those who said they did know of such facilities were mainly state or local government centers. An institute or society also had fairly high mention for the blinded man, and a hospital had high mention for the stroke victim and leg amputee. Major facilities named were:

	Publicly supported or low-cost facilities for rehabilitation for		
	Blinded man	Stroke victim	Leg amputee
Number of respondents	48	53	62
	%	%	%
State rehabilitation center, vocational center	27	21	26
City, county rehabilitation center, vocational center	19	11	13
Institute for the disabled (Perkins, Goodwill, Braille)	17	6	6
A society, a center (Red Feather)	19	4	-
Curative workshop, specialized school	13	4	3
Vocational rehabilitation center, vocational school	6	11	10
City, county public health, welfare, health and welfare	6	11	11
Hospital	6	25	27

Major Problems Doctors See In Getting Rehabilitation Services For The Disabled

When asked about what the major problems were in their area in getting rehabilitation services for disabled people, about two-thirds of the doctors cited something they saw as a problem. Only twelve per cent said there were no problems, and 19% said they didn't know what the problems were. This latter figure is another indication of the extent to which doctors are not knowledgeable about rehabilitation services.

A variety of problems were cited by doctors. The three major problems most mentioned were a lack of facilities, long waiting periods, and a lack of interest or desire to be helped on the part of the disabled person. The most mentioned problems were:

Number of respondents	100
	%
Lack of facilities, not enough institutions and centers available	21
Long waiting periods, waiting lists; takes a long time to get anything done	14
Lack of interest, desire to be helped on part of disabled person	14
Shortage of personnel, trained personnel	9
Lack of knowledge, where to send people	7
Finances is a problem, costs are expensive	7

AWARENESS OF ADVERTISING

All three groups interviewed--the general public, those in the "disabled" household sample, and doctors were asked if they had seen or heard any advertising in the past month or so on where to get information on help for the disabled, and if so, what the advertising said. The basic purpose of the question was to provide a bench mark against which to measure the effectiveness of the new campaign. In and of itself, however, it shows something of the awareness of advertising aimed at help for the disabled by all sources.

The group with the highest recall of advertising was the general public in non-disabled homes, with 30% saying they had seen advertising. Next highest recall was by respondents in "disabled" households--24%. Lowest recall of advertising was among doctors--15%.

The major advertising recalled was that on where to get information locally for handicapped people, followed by advertising on specific types of handicaps (mental retardation, multiple sclerosis, March of Dimes). The "Hire the Handicapped" campaign also had specific mention, though at a low level. The new campaign had minor recall--and it is possible that some car card advertising could have been seen by the time of this study. A summary of advertising recall is as shown in the following table:

	Respondents in Non-disabled households	Disabled households	Doctors
Number of respondents	926	481	100
	%	%	%
YES--HAVE SEEN ADVERTISING	30	24	15
Told where to get information locally for handicapped people	10	5	4
Saw ad for specific type of handicap (mental retardation, multiple sclerosis, March of Dimes)	8	5	2
"Hire the Handicapped"	3	2	4
Fund drives for organizations dealing with the handicapped	3	1	-
United Fund helps the handicapped	2	1	-
Goodwill Industries helps the handicapped	1	2	-
Social Security offers information	*	1	-
Write Washington, D. C. for information	*	1	-

*Less than .5 per cent

Perhaps the most significant thing in these answers is the lower penetration of advertising among the two most important groups to be reached--people who have someone disabled in their household and doctors. Also of interest, however, is the fact that one of the major kinds of advertising to make an impact on all three groups is that on where to get information locally for handicapped people. This indicates to us both an interest in and a need for the kind of advertising the current campaign undertakes.

GPO 881-877